



Referral Form

E-Mail: Services@KaibabAZ.com

Phone: 928-607-1280

Services Requested for: _____

AHCCCS ID# _____

Health Plan: Steward Care 1st CRS UHC Mercy Care

ICD-10CM Primary Diagnosis: _____

CLIENT NEEDS	GOALS & OBJECTIVES	SERVICES REQUESTED
<p>Kaibab's services are based in applied behavior analysis (ABA) which involve:</p> <ol style="list-style-type: none"> 1. Assessment: review of records, interviews with caregivers, on-site observations in typical routines and settings, and direct work with the client. 2. Recommendations: skills to learn and/or behaviors to increase/decrease. 3. Work with the person: teach target skills and practice alternative ways to handle difficult situations. 4. Work with parents or other caregivers: assist with implementation of the plan after discharge from our services. 5. Measure and Analyze progress: assess if the plan is working or requires revision. <p><input type="checkbox"/> CLIENT'S CHALLENGING BEHAVIORS: _____</p> <p>_____</p> <p><input type="checkbox"/> CLIENT'S IDENTIFIED STRESSORS (e.g., social situations, demands, being denied something preferred, etc): _____</p> <p>_____</p> <p><input type="checkbox"/> SETTINGS OF GREATEST CONCERN: _____</p> <p>_____</p> <p><input type="checkbox"/> ROUTINES OF GREATEST CONCERN: _____</p> <p>_____</p> <p><input type="checkbox"/> SKILLS FOR DAILY ACTIVITIES (e.g., personal care, getting along with others, school work, chores, community living, etc...): _____</p> <p>_____</p> <p><input type="checkbox"/> FREQUENCY OF BEHAVIOR (e.g. ___ times per hour/day/week/month): _____</p>	<p><input type="checkbox"/> Prevent or decrease use of destructive, inappropriate, or ineffective behaviors when expressing anger or communicating needs</p> <p><input type="checkbox"/> Develop ability to achieve and maintain satisfying relationship or partnership.</p> <p><input type="checkbox"/> Develop ability to reduce intensity to better cope with daily stressors</p> <p><input type="checkbox"/> Develop ability to complete tasks and activities as independently as possible.</p> <p><input type="checkbox"/> Provide and maintain schedule and plan for consultation services for Positive Behavior Support.</p> <p><input type="checkbox"/> Teach and reinforce the following skills:</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Review Behavioral Data/Documents:</p> <p>_____</p> <p><input type="checkbox"/> Other: _____</p>	<p>In order to accomplish the above successfully, Kaibab will most often use some of the following services:</p> <p><input type="checkbox"/> Conduct Assessment & Behavior Support/Intervention Plan</p> <p><input type="checkbox"/> Counseling</p> <p><input type="checkbox"/> Case Management to Participate in Team Meetings</p> <p><input type="checkbox"/> Skillstraining on techniques included in the ABA Program or Behavior Support/Intervention Plan</p> <p><input type="checkbox"/> Technical assistance to faculty/staff regarding specialized programs or individual student</p> <p><input type="checkbox"/> In-service and/or coaching to provider organization, school, or other groups regarding ABA or Positive Behavior Support services in general</p> <p><input type="checkbox"/> Parent Education Classes to parents seeking long term solutions for their child/teen</p> <p>Services Begin Date: _____</p> <p>Services End Date: _____</p> <p>Service Frequency:</p> <p><input type="checkbox"/> _____ hour(s) equaling _____ units</p> <p><input type="checkbox"/> _____ to _____ times per month</p>



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Parent/Legal Guardian: _____	Primary Phone: _____
Address: _____	City: _____ State: _____ Zip Code: _____
Client Residence: _____	City: _____ Home Phone: _____
Tribal Affiliation (If Applicable): _____	Date of Birth: _____
Current Case Manager: _____	Primary Phone: _____

Previously completed assessments: _____

Date new/revised behavior plan is due: ____/____/____

Related Support Services:

- | | | | |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> Counseling | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Speech Therapy | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Music Therapy | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Vocational Training | <input type="checkbox"/> Other: _____ |

*** PLEASE PROVIDE THE FOLLOWING DOCUMENTS WITH THIS FORM FOR EACH REFERRAL SOURCE***

**** REFERRALS WILL BEGIN WHEN ALL OF THE DOCUMENTS HAVE BEEN RECEIVED**

- | | |
|--|--|
| <input type="checkbox"/> Core Assessment (If accessible) | <input type="checkbox"/> Third Party Liability (TPL) Information |
| <input type="checkbox"/> Health Services Plan with Kaibab Behavioral Services Listed | <input type="checkbox"/> Most Current Psychiatric Note |
| <input type="checkbox"/> Consents with Kaibab Behavioral Services | |

My signature below indicates that I agree with the services requested above:

Client Signature _____ Date _____ Signature of Legally Responsible Party _____ Date _____

Referring Agency Representative Signature _____ Date _____ Supervisor Signature (If Applicable) _____ Date _____